

San Joaquin County Low Income Health Program Handbook

What is the Low Income Health Program?

The Low Income Health Program (LIHP) provides medical coverage to San Joaquin County residents who meet certain requirements. Under this federally funded program, you are assigned to a Primary Care Physician (PCP) who not only takes care of you when you are sick, but also for regular and preventive care to help you stay healthy. Your assigned PCP will coordinate your medical care within the LIHP Provider Network, which is a list of participating physicians and medical service providers.

This program provides certain health care benefits for people who qualify. When you enroll, you become eligible for those health care benefits. You must get your health care according to the rules of the program. That means only going to providers that are part of the provider network. It also means getting approval in advance (called prior authorization) before seeing a specialist, getting hospital care, or getting some medications.

Please see the “Description of Low Income Health Program Medical Services” for more information on medical coverage.

The LIHP program is located at 500 West Hospital Road in French Camp, Ca. on the campus of the San Joaquin General Hospital. Please see the Eligibility and Enrollment sections below for more information.

Eligibility for the Low Income Health Program

Enrollment in the LIHP is voluntary. You must meet the following eligibility criteria:

- You are a U.S. citizen, a Legal Permanent Resident for at least 5 years, or a Qualified Alien as defined by federal law who is not subject to the 5 year exclusion
- You are a non-pregnant individual between 19 through 64 years of age
- You live in San Joaquin County
- You are not eligible for any federally funded Medicaid health insurance programs such as Medi-Cal or Healthy Families
- Your income does not exceed 80% of the Federal Poverty Level (FPL)

If you are eligible but the program is unable to accept new enrollees, you will be placed on a waiting list. People on the waiting list will be contacted when there is availability to enroll in LIHP on a first-come first-served basis. It is your responsibility to ensure your contact information is current with LIHP staff.

Enrollment in the Low Income Health Program

To enroll in the program, you must submit an application and provide appropriate documentation. The LIHP staff verifies the information and determines eligibility. If determined eligible, your effective date is the first day of the month in which the application is received and the eligibility requirements are met. For those who do not meet the eligibility requirements during the month of application, the beginning date of coverage is the first day of the first month in which the above criteria are met. If an applicant is determined otherwise eligible but has not provided required documentation of citizenship status, he or she is enrolled pending receipt of citizenship documentation. Income and residency will be verified on an annual basis.

Upon certification of your enrollment at the eligibility and financial screening interview or follow-up appointment, you will receive a LIHP ID Card which identifies your PCP and lists important contact numbers such as Member Services. It is important to keep your LIHP ID Card with you at all times.

A Provider Directory details the participating providers you can use unless they are no longer accepting patients at the time. The Provider Directory includes primary care and specialty providers in the community. Included in our Network are Community Medical Centers which are Federally Qualified Health Centers (FQHC). You may obtain an updated Provider Directory by calling Member Services at 1-866-936-7526 or (209) 942-6306 (TTD/TTY).

You may use the Provider Directory to initially choose or change your PCP. You will have the opportunity to change your PCP once every twelve months in the anniversary month of enrollment. In the event you do not choose a PCP, staff will assign a PCP to you based on your prior physician history. You may receive assistance with choosing or changing your PCP by calling Member Services at 1-866-936-7526 or (209) 942-6306 (TTD/TTY).

Women can choose any participating PCP for routine or preventative GYN care. They may also choose to receive primary care services from their PCP and women's health services from an OB/GYN. Contact Member Services to make this choice at 1-866-936-7526 or (209) 942-6306 (TTD/TTY).

Your PCP will refer you to the proper care and services. If you go outside the Provider Directory without prior authorization, the LIHP will not provide payment for these services.

Emergency services received from an out-of-network provider will be covered. If you go to an Emergency Room, the staff at the Emergency Room should call to notify LIHP of your treatment within 24 hours of the service.

Case Management services are available for LIHP enrollees, and will be identified and discussed with you through your PCP. Case Management is provided to enrollees who have complicated medical conditions and need assistance in obtaining specialty services.

Low Income Health Program Interpretive Services

Member Services can help you choose a doctor or medical group who speaks your language. If you need interpreter services to access medical care at a service site, you should call your PCP or participating provider to request this service. If your PCP or participating provider is not able to meet your language needs, you can ask Member Services to have an interpreter available for discussions of medical care at no charge. Call Member Services before your visit if you need an interpreter at your medical appointment.

Description of Low Income Health Program Medical Services

There are no co-pays for the LIHP Program.

All non-emergency covered services must be provided by a participating provider unless prior authorization is obtained.

Emergency care does not need prior authorization. You may seek care at the nearest hospital, which may or may not be a participating provider.

LIHP Core Benefits include:

Physician Services – All medically necessary primary care and specialty care physician services are a covered benefit. These services are performed by physicians or by physician assistants or nurse practitioners under a physician's supervision, and include, but are not limited to, office calls, surgery, anesthesiology, radiology, consultations, home and institutional calls. Specialty care services will require a referral by your primary care doctor for prior authorization approval.

Outpatient physician services are covered if they are medically necessary. Inpatient physician services are covered only during an authorized inpatient hospital stay. Exclusions include Physician Services obtained from physicians not included in the LIHP Provider Network, unless prior authorization is obtained. Exclusions also include immunizations required for travel or as required for employment; and exams for non-medical needs such as getting or keeping a job, getting a license, or getting insurance.

Outpatient Hospital Services – Medically necessary services that are provided under the direction of a doctor, but do not include an overnight stay. They may include any doctor-ordered necessary diagnostic services or specialty care. Your Physician must determine if it is medically necessary, and prior authorization must be obtained.

Inpatient Hospital Services – Medically necessary services received during an inpatient hospital stay. Your physician must determine it is medically necessary, and prior authorization must be obtained. Exclusions include personal or comfort items and private room unless medically necessary.

Emergency Medical Transportation Services –Emergency ambulance transportation to the nearest hospital for emergency care is covered. Emergency medical transportation services do not need prior authorization of coverage from the LIHP. Emergency medical transportation may be provided by any licensed emergency medical transportation provider. The LIHP will not cover ambulance services if an enrollee did not reasonably believe that (1) an emergency condition existed, and (2) the condition required ambulance transport services.

Non-Emergency Medical Transportation Services – Transportation for non-emergency medical purposes, when medically necessary, such as lack of appropriate transportation to medical appointments or services. You must obtain prior authorization for non-emergency medical transportation services, and it must be obtained from a participating provider. Non-medical transportation services such as passenger car, taxicab or other forms of public transportation are not covered.

Medical Equipment & Supplies – Medical equipment and supplies necessary for the continuous care of the patient and to meet the medical needs of the patient are covered benefits.

Examples of medical equipment include, but are not limited to: oxygen and oxygen equipment; blood glucose monitors; insulin pumps; and nebulizer machines. Examples of medical supplies include, but are not limited to: ostomy bags; urinary catheters; and blood glucose testing strips.

Your physician must determine if medical equipment and supplies are medically necessary. Prior authorization must be obtained for any medical equipment and supplies; also they must be obtained from a participating provider.

Laboratory and Radiology Services – Laboratory and Radiology services consist of appropriate examinations, tests, and other diagnostic tests or procedures, for the prevention, diagnosis, and treatment of illness or injury. Your physician must determine if these services are medically necessary and prior authorization must be obtained for some laboratory and radiology services. They must be performed by a participating provider.

Physical Therapy – Services for medical problems or other health-related conditions, illnesses, or injuries that limit the ability to move and perform functional activities related to daily living. Your physician must determine if physical thereapy is medically necessary and prior authorization must be obtained. Physical Therapy must be obtained from a participating provider.

Orthotics and Prosthetics – Orthotics are medical supplies that support bones and joints. Prosthetics are medical devices that replace a body part. Orthotics and Prosthetics are covered when such appliances are necessary for the restoration of function or replacement of body parts. Your physician must determine it is medically necessary and prior authorization must be obtained. The LIHP may decide whether to replace or repair an item. Orthotics and Prosthetics must be obtained from a participating provider.

Specialty Services - Your PCP will request specialty services, such as referrals for orthopedics or surgery , for you when deemed medically necessary and not within the scope of primary care services.

To receive specialty services, your PCP will make a referral indicating how many times you may see the specialist and the approved course of treatment. Your PCP will choose a participating specialist physician, participating hospital, or other participating provider from whom you may receive services. If there is no participating provider available to perform a medically necessary covered service, your PCP will refer you to a non-participating provider for the services, after getting prior authorization of coverage from the LIHP.

Exclusions include hearing aids and audiology services, and surgically implanted hearing devices.

Mental Health Services - In order to receive mental health services as a covered benefit, your PCP must provide a referral to you for a mental health specialist assessment. Mental Health services are limited to individuals with a significant impairment in an important area of life functioning, or a probability of significant deterioration in an important area of life functioning. Members are entitled to up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility; psychiatric pharmaceuticals; and up to 12 outpatient encounters per year.

The mental health specialist must determine that the enrollee has a mental health condition listed in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, and the enrollee has one or more of the following impairment, symptoms, or behavior:

- A current danger to self, others, or property
- Unable to provide for or utilize food, shelter, or clothing
- Present a severe risk to the enrollee's health and safety
- Require further psychiatric evaluation or medication treatment

Prescription Medicines – Prescription medicines from your participating provider must be filled at a pharmacy included in the Provider Directory and included on the LIHP drug formulary. If your participating provider prescribes a drug or over-the-counter items not on the formulary, the LIHP will not pay for them

unless medically necessary and prior authorization was obtained. You may obtain a copy of the LIHP drug formulary by calling Member Services at 1-866-936-7526 or (209) 942-6306 (TTD/TTY).

Urgent Appointments – If you have an urgent care need during regular business hours, contact your physician, Urgent appointments will be scheduled within 48 hours. You also can call Member Services at 1-866-936-7526 or (209) 942-6306 (TTD/TTY) and they will direct you where to go for care.

After Hour Services - If you need urgent care or medical advice after hours or on the weekends, you may call your physician's office and talk to the physician on call. You also can call Member Services at 1-866-936-7526 or (209) 942-6306 (TTD/TTY), and they will tell you where to go for care. If you need interpretive services while receiving after hour services, please make Member Services aware, and such services will be provided to you at no cost.

Emergency Care – An emergency is a medical or psychiatric condition, including severe pain, manifesting itself by acute symptoms of a sufficient severity such that the absence of immediate medical attention could be reasonably expected to result in any of the following:

- Placing the individual's health in serious jeopardy
- Causing serious impairment to bodily functions
- Causing serious dysfunction of any bodily organs or parts

If you are having a medical emergency, call 911, go to the San Joaquin General Hospital (SJGH) Emergency Department located at 500 West Hospital Road in French Camp, or go to the nearest emergency medical center. Emergency services are available at SJGH, 24 hours, 7 days a week.

Emergency care does not need prior authorization of coverage from LIHP. If you receive emergency care at a facility other than SJGH (an out-of-network provider, regardless if the provider is in or outside of the County), the hospital you received services from must notify your PCP or Member Services within 24 hours of your admission into the emergency department in order for these emergency care services to be covered..

Post-Stabilization Care Services – Once the emergency condition has been stabilized, prior authorization of coverage is required for any more services. Care in the hospital after the enrollee's emergency condition has stabilized is referred to as post-stabilization care.

If you received emergency care at SJGH and are admitted to the hospital, your PCP should be contacted for post-stabilization care. Post-stabilization care after an emergency visit, if not provided at SJGH, is not a covered benefit without prior authorization. Out-of-network emergency centers must call Member Services to obtain prior authorization and payment for the post-stabilization services.

Excluded Services - The following are excluded benefits under the LIHP:

- Organ transplants
- Bariatric surgery
- Infertility related services

Disenrolling in the Low Income Health Program

The LIHP is a voluntary program and an enrollee may decide at any time to disenroll by calling Member Services at 1-866-936-7526; (209) 942-6306 (TTD/TTY) or by calling Eligibility and Enrollment (209)

468-6679. You may also make an oral or written notification to the Eligibility and Enrollment office located at San Joaquin General Hospital at 500 W. Hospital Road, French Camp.

Disenrollment of a LIHP enrollee is mandatory when:

- Enrollee has been determined to be unable to provide documentation of citizenship
- Enrollee does not provide or no longer meets program eligibility requirements, such as residency or income
- Enrollee exceeds income limits allowed for the program
- Enrollee voluntarily disenrolls from the program
- Enrollee no longer resides in San Joaquin County
- Enrollee becomes institutionalized in an Institutions for Mental Diseases
- Enrollee attains the age of 65
- Enrollee is no longer living

Enrollees may voluntarily disenroll without cause at any time by submitting an oral or written request for disenrollment to the LIHP.

If you are disenrolled for any reason, we will send you a letter notifying you about our action. Please see below for your grievance and appeal rights.

Low Income Health Program Complaints

If you have a complaint about any services received or action taken by LIHP, call Member Services to assist you with the appeal or grievance process. You can obtain the LIHP Hearing and Appeals Process Policy and Procedures from Member Services as well.

A Notice of Action (NOA) is a formal letter notifying you that a medical service has been denied or modified. If an enrollee receives a NOA, a written or oral appeal may be made to LIHP within 60 calendar days of the date of the NOA. To file an internal grievance, enrollees have 60 calendar days from the date of the incident giving rise to the grievance. An appeal is a request for reconsideration of a denial of service, authorization, or enrollment/eligibility determination. A grievance is anything other than an appeal.

The LIHP will acknowledge receipt in writing of each appeal and grievance. LIHP must mail written notice of resolution within 45 calendar days of receipt of enrollee's appeal. If your appeal involves an imminent and serious threat to your health, you may request an expedited resolution of appeal and LIHP must mail written notice of resolution of the appeal within 3 working days of receipt of enrollee's appeal. LIHP must provide oral or written notice of disposition of grievance within 60 calendar days of receipt of enrollee's grievance.

Timeframes on the above may be extended by up to 14 calendar days if either the enrollee requests it or the LIHP can show, to the satisfaction of the Department of Health Care Services upon its request, that there is a need for additional information and how the delay is in the enrollee's interest. LIHP must provide written notice of the reason for the delay to the enrollee, unless requested by the enrollee.

A State fair hearing may be requested within 90 calendar days of the date of the notice of resolution of the appeal. Exhaustion of the appeal process will be required of a LIHP applicant or enrollee prior

to filing a request for a State fair hearing to appeal a NOA. Grievances will not be appealable to a State fair hearing. To request a State fair hearing:

California Department of Social Services
State Hearings Division
PO Box 944243, MS-19-37
Sacramento, CA 94244-2430
1-800-952-5253
Hearing and speech impaired enrollees may call:
1-800-952-8349

Low Income Health Program General Information

Payment to Providers – The LIHP contracts with a network of local doctors, medical groups, pharmacies, hospitals, and other providers to provide services to enrollees. We pay providers in the following ways:

- **Fee-for-service** – This means we reimburse the provider after each service or visit. This system includes periodic financial incentives the doctors may earn for achieving established quality measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS).
- **Pier diem rate** – This is a set rate we pay to participating hospitals per day. We negotiate rates with hospitals and physicians that are outside San Joaquin County that provide emergency or other referral services.

Any enrollee who wants more information about our reimbursement methodology can ask for a full disclosure from Member Services at 1-866-936-7526; (209) 942-6306 (TTD/TTY).

Advance Health Care Directives – Advance Health Care Directives help you make healthcare decisions for yourself now, in case you are unable to speak for yourself in the future. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatment you want.

In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a Power of Attorney For Health Care. The part where you can express what you want done is called an Individual Health Care Instruction. Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

For more information on Advance Health Care Directives, please call the Department of Health Care Services at (916) 445-4171 for a free brochure, or call Member Services at: 1-866-936-7526; (209) 942-6306 (TTD/TTY).

Call Member Services to receive information regarding any changes to the law. The information shall reflect any changes to state law regarding Advance Health Care Directives as soon as possible, but no later than 90 days after the effective date of the change.

Low Income Health Program Policies & Procedures – You can request a copy of San Joaquin County's Low Income Health Program Clinical and Administrative Policies and Procedures by contacting Administration at (209) 468-5610.

Notice of Rights – The LIHP must notify you of any significant changes in your rights at least 30 days before the intended effective date of change.

Low Income Health Program Contacts

Eligibility and Enrollment (209) 468-6679

Member Services 1-866-936-7526; (209) 942-6306 (TTD/TTY)

Administration (209) 468-5610